



## Tobacco Use Certification Form

Illinois Preexisting Condition Insurance Plan  
www.insurance.illinois.gov/ipxp

The top portion of this form must be signed and dated by the applicant. The bottom portion must be completed, signed and dated by your physician and returned within 60 days of your effective date of coverage. If we do not receive this form within the 60 days, your premium will be taken from the Tobacco User rate tables, regardless of how you answered the tobacco use question within the application.

Return this form to:

**Health Alliance Medical Plans**  
**Attn: Illinois Preexisting Condition Insurance Plan**  
**301 S. Vine Street**  
**Urbana, IL 61801**  
**Fax: (217) 337-3425**

**DO NOT SEND PREMIUM PAYMENTS TO THE ABOVE ADDRESS. DO NOT INCLUDE PAYMENTS WITH THIS FORM.**

<i>last name</i>	<i>first name</i>	<i>middle name</i>	<i>effective date</i>
<i>address</i>		<i>social security number</i>	<i>birth date</i>
<i>city</i>	<i>state</i>	<i>zip code</i>	<i>home phone number</i>
<i>signature of primary insured</i>		<i>date mm/dd/yyyy</i>	
<i>signature of parent (if insured is under age 18) or legal guardian (if insured is legally incompetent)</i>		<i>date mm/dd/yyyy</i>	

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### Physician's Certification – include the NPI:

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<i>physician's last name</i>	<i>physician's first name</i>	<i>physician's middle name</i>	<i>physician's NPI</i>
The person identified within this form has been my patient since: _____ <i>date mm/dd/yyyy</i>			

Physician: Please indicate below the most appropriate answer as to whether this patient is a tobacco user. Tobacco use includes any form of tobacco products, including, but not limited to, cigarettes, pipes, cigars, cigarillos, snuff, or chewing tobacco products.

The patient has, within the last 12 months:

- used** tobacco and has been confirmed by a test on \_\_\_\_/\_\_\_\_/\_\_\_\_.
- used** tobacco based on patient disclosure or other.
- not used** tobacco and has been confirmed by a test on \_\_\_\_/\_\_\_\_/\_\_\_\_.
- not used** tobacco based on patient disclosure or other.

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*signature of physician**date mm/dd/yyyy*